

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/28/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155760	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 03 B. WING _____		(X3) DATE SURVEY COMPLETED R 03/27/2024
NAME OF PROVIDER OR SUPPLIER WATERFORD CROSSING			STREET ADDRESS, CITY, STATE, ZIP CODE 1332 WATERFORD CIR GOSHEN, IN 46526		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
{K 000}	<p>INITIAL COMMENTS</p> <p>A Post Survey Revisit (PSR) to the Life Safety Code Recertification and State Licensure Survey conducted on 03/04/24 was conducted by the Indiana Department of Health in accordance 42 CFR Subpart 483.90(a).</p> <p>Survey Date: 03/27/24</p> <p>Facility Number: 011150 Provider Number: 155760 AIM Number: 200831020</p> <p>At this PSR survey, Waterford Crossing was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>The facility consists of building 01 the original build and building 03 the 2023 memory care addition.</p> <p>Building 01 is one story and was determined to be of Type V (111) construction and was fully sprinkled. The facility has a monitored fire alarm system with smoke detection in the corridors, areas open to the corridors and hard-wired smoke detectors in the resident rooms. The facility has a capacity of 87 and had a census of 77 at the time of this survey.</p> <p>All areas where the residents have customary access were sprinkled. All areas providing facility services were sprinkled.</p>	{K 000}			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{K 000}	Continued From page 1	{K 000}			
{K 000}	Quality Review completed on 03/27/24	{K 000}			
{K 000}	INITIAL COMMENTS	{K 000}			
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{K 000}	Continued From page 2 services were sprinkled. Quality Review completed on 03/27/24	{K 000}		